

<b>Case Number:</b>	CM14-0018698		
<b>Date Assigned:</b>	04/18/2014	<b>Date of Injury:</b>	06/23/2006
<b>Decision Date:</b>	07/02/2014	<b>UR Denial Date:</b>	02/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 68-year-old female who reported an injury on 06/23/2006 secondary to an unknown mechanism of injury. The diagnoses include severe degenerative disc disease with stenosis, rotator cuff syndrome, thoracic/lumbosacral radiculitis, and carpal tunnel syndrome. The injured worker was evaluated on 01/16/2014 for reports of unchanged daily neck, low back and left shoulder complaints. The exam noted guarded gait, moderate decrease of range of motion to cervical spine and moderate to severe decrease of range of motion of the lumbar spine. The treatment plan included continuation of the medication plan. The request for authorization is not in the documentation provided.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**NORCO (HYDROCODONE/APAP) 10/325MG #120, ONE (1) BY MOUTH EVERY SIX (6) HOURS, AS NEEDED FOR PAIN: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 74-96.

**Decision rationale:** The Chronic Pain Guidelines recommend opioids for the on-going management of chronic pain with ongoing review of the efficacy of the medication, functional status, appropriate medication use and side effects. There is a lack of evidence of the current efficacy of the medication, functional status, appropriate medication use, and side effects. Therefore, based on the documentation provided, the request is not medically necessary.

**NORFLEX ORPHENADRINE 100MG #60, ONE (1) BY MOUTH TWICE A DAY:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS (FOR PAIN).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS (FOR PAIN) Page(s): 63-66.

**Decision rationale:** The Chronic Pain Guidelines recommend the use of muscle relaxants as a second-line option for short-term treatment of acute exacerbations in patients with low back pain. There is a lack of evidence of muscle spasms upon exam. The medication has been prescribed since at least 12/09/2013, which exceeds the length of time to be considered short-term. Therefore, based on the documentation provided, the request is not medically necessary.

**DENDRACIN TOPICAL LOTION, BRAND NAME ONLY; 120ML #2, APPLY TWICE A DAY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

**Decision rationale:** The Chronic Pain Guidelines indicate the use of any compound topical medication containing any non-recommended medication is not recommended. Dendracin contains methyl salicylate, benzocaine and menthol lotion. Lidocaine and by extension benzocaine is not recommended as a topical analgesic other than as a lidoderm patch. Therefore, based on the documentation provided, the request is not medically necessary.